Anthem BlueCross

Healthy You

SMARTER CHOICES FOR BETTER LIVING

Summer 2014

Zesty Fish Tacos

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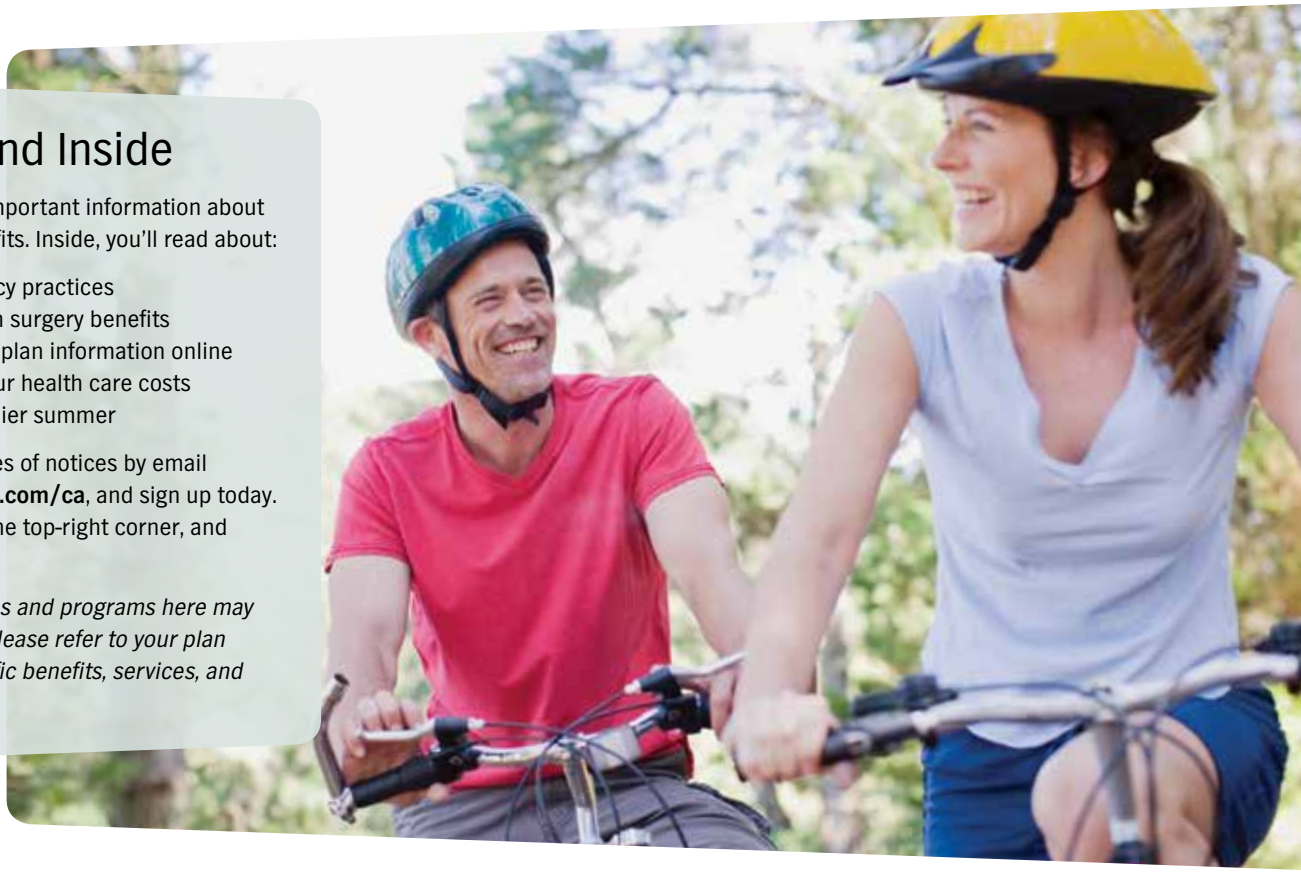
What You'll Find Inside

Every year, we send you important information about your rights and your benefits. Inside, you'll read about:

- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits
- Where to find helpful plan information online
- Tips for managing your health care costs
- Ways to have a healthier summer

Want to receive these types of notices by email instead? Log in at **anthem.com/ca**, and sign up today. Select the **Profile** link in the top-right corner, and select **Email Preferences**.

Please note: Some services and programs here may not be part of your plan. Please refer to your plan documents for your specific benefits, services, and exclusions.



6 Ways to Get Moving Now!

Burn calories and shape up with fun activities for sunny weather

The weather is fine, so escape the stuffy gym and make time for fresh-air fun. The best part? You have so many options to get moving. "Doing the same physical activity day after day gets boring," says Ruth Frechman, CPT, RDN, a personal trainer and dietitian in Burbank, CA. Try these ideas:

Hit the pavement

Walking or running is an easy, free, and effective workout. Do it when it works for you. Take a walk after a meal, or lace up your sneakers for a run when you're up for a more vigorous workout.
Burn 100 calories walking at an easy pace or 430 calories running at a vigorous pace. (All calorie counts are based on a 160-pound person and 30 minutes of activity.)

Play in the yard

Fitness doesn't have to be work. Why not play? Even better, get active with family or friends with a game of badminton or soccer.
Burn 200 calories playing badminton or 255 calories playing soccer.

Take a dip

Refresh your cardio routine, and get your heart rate up with a splash around the pool. Bonus: Swimming is gentle on the joints.
Burn 220 calories swimming at a leisurely pace.

Spin your wheels

Break the cycle of your boring workouts. Strap on a helmet, and bike around your neighborhood or in a local park.
Burn 150 calories biking at a leisurely pace.

Go on an adventure

Walking along trails or up and down hills gives your whole lower body a terrific workout.
Burn 220 calories hiking.

Exercise your green thumb

Gardening helps your yard and your health, thanks to all the pushing and pulling movements.
Burn 140 calories gardening.

PHOTOS: ALAMY (TOP); CORBIS (BOTTOM)

Looking for Information About Your Plan?

Every year, we share information about your health plan rights and benefits so you can get the most from your plan. This year, we've gathered this important information in one convenient place online, so you can access it anytime (see below). You can learn about your rights and responsibilities as a member, as well as:

About benefits and services related to your coverage, including:

- Covered services, and any benefits that are not covered or are limited.
- Copayments and costs you will have to share (if any).
- The steps we take when evaluating new treatments to be considered as covered benefits.
- For plans with our pharmacy benefit, about your prescription drug plan, including the drug list/formulary and the pharmaceutical management procedures that may apply.

Information about how to access care:

- Primary and specialty care, behavioral health, and hospital services.
- After normal office hours or when you are out of the plan's service area.

How to perform key functions as a member of the plan, such as:

- Search for a provider, hospital, or specialist in our network, and learn about their qualifications.
- File a claim for covered services.
- To get the best care, sharing information about all the care you receive with all your providers.

About important programs we utilize, such as:

- Our Quality Improvement Program, and how we use this information to help improve the quality of our benefits and services.
- Our Case Management Program, and how to sign up if you have a serious medical condition.

Other information you'll find:

- Organ donors save thousands of lives; consider being one.
- What all women need to know: finding cancer early is the best way to treat it and beat it.

To find your information, go to:
anthem.com/ca/summerguide2988

If you need a copy of this information on the web, call Member Services at the number on your member ID card.

Save Money on Your Health Care

Tools and resources that help cut costs

A little planning can go a long way, especially when it comes to your health care and money. Here are some easy ways to save:

Choose an in-network doctor or facility
When you stay in your health plan network, you save money. Go to **anthem.com/ca**, and use the **Find a Doctor** tool.

Get checkups, flu shots, and other preventive care
For many plans, preventive care is free. If you're not sure which tests and shots you need, go to **anthem.com/ca**. Select the **Health and Wellness** tab, and check the **Preventive Health Guidelines**.

Know your emergency room alternatives
Need a doctor? If you're not experiencing a life-threatening medical issue, try your doctor's office or an urgent care center. Both can treat you for a cut, sprain, or minor fever. They may cost you less than an ER, and you might get in and out faster, too.

Get discounts on healthy living products and services
Save money on select weight loss programs, allergy control products, and more tools for healthy living. Log in at **anthem.com/ca**, and click on **Discounts**.

Ask your doctor about generic medicine
Generic versions of your medicine might look a little different, but the active ingredients are the same as a brand-name medicine. Choosing generic could save you hundreds of dollars a year.

PHOTO: THINKSTOCK

7 Steps to a Safer Summer

Easy solutions for seasonal problems

Bug bites, scrapes, rashes, and other summer health problems can put a damper on fun. Luckily, most of these minor problems can be fixed with easy solutions. Try these tips from Daniel Spogen, MD, of the American Academy of Family Physicians. Here's what to do for:

Bug Bites

If you're going to be spending a lot of time outdoors, wear bug repellent and protective clothing like long sleeves. If you get bitten, take an antihistamine, or rub an antihistamine cream on the bite. The bite should heal after three or four days, Dr. Spogen says. If days pass and it looks worse, it's best to check with your doctor.

Rashes

The most common rashes during this time of year are from poison ivy or poison oak. Wear protective clothing if you're going to be in heavily wooded areas. Try to avoid "leaves of three." Poison ivy has pointed leaves in groups of three, and poison oak has rounded leaves in groups of three. When you go inside, wash your skin thoroughly. If you develop a rash, resist the urge to scratch. That spreads the rash. Apply an ice pack, and take an antihistamine pill or rub on a hydrocortisone cream. If the rash doesn't improve after three days, see a doctor.

Poison Ivy

Poison Oak

Cuts and Scrapes

Even when you're careful, you can't always avoid cuts and scrapes. You need two things to heal: moisture and bandages. Apply antibiotic ointment to the wound before applying the bandage, and change the bandage as often as needed. "Drying out delays healing," says Dr. Spogen.

Sunburn

If you're going to be spending time in the sun, apply sunscreen 30 minutes before going out, and reapply every 90 minutes as needed. Be sure your sunscreen is "broad spectrum" and has an SPF of at least 15. If you start looking red, head indoors, and take an anti-inflammatory medicine like ibuprofen, Dr. Spogen says. Apply a cooling lotion to soothe skin and keep it moisturized.

Food Poisoning

Don't leave your potato salad on the picnic table too long. Too much heat and sun can cause bacteria to form, Dr. Spogen says. Avoid eating any food that has been sitting out in the sun for more than two hours or more than one hour if it's warmer than 90°F. To settle an upset stomach, take small sips of ginger ale.

Dehydration

In warm weather, you may lose more water than you realize. Keep drinking fluids, even if you don't feel thirsty. If you have a dry mouth or dark urine, you may be dehydrated. If you start to feel light-headed and your heart starts racing, you may be severely dehydrated. Go to an urgent care center or the ER.

Swimmer's Ear

Splashing around in a pool is fun, but water that becomes trapped in your ear isn't. In fact, it can lead to infection. To keep your ear nice and dry, dilute rubbing alcohol with white vinegar, and put a couple of drops in each ear.

PHOTOS: SUPERSTOCK (TOP); ISTOCK, THINKSTOCK (BOTTOM)

Women's Health and Cancer Rights Act

For the Women's Health and Cancer Rights Act, the federal DOL website has this information: **dol.gov/ebsa/publications/whcra.html**.

In 1998, Congress passed legislation that outlines specific coverage that all group health plans and health insurance carriers offering medical and surgical benefits for mastectomies must offer to patients. This coverage is for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to provide a symmetrical appearance
- Prostheses and the treatment of physical complications during all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the member

Coverage of these services is subject to the same copayments, deductibles, and coinsurance percentages, if any, as other services covered under your plan. Please refer to your Certificate of Coverage, Member Handbook, or Schedule of Benefits for more specific information. Please contact your administrator or call Member Services at the phone number on your identification card for more information.

Getting In to See the Doctor

How long should it really take to get a doctor appointment? Not long at all. We're committed to making sure you have access to the care you need — when you need it. So here's a brief rundown of how long it should take you to get an appointment.

To learn more about your health care and benefits, please see your Certificate or Evidence of Coverage, or call the customer service phone number on your ID card. You also can call if you are having difficulty getting an appointment within waiting times.

Standard waiting times for medical care:

Type of care	Standard waiting time
Non-urgent care appointments with your main doctor	An appointment time within 10 business days from the time you ask for it
Urgent care appointments that do not need a prior OK (this is called prior authorization)	An appointment time within 48 hours from the time you ask for it
Non-urgent care appointments with specialists	An appointment time within 15 business days from the time you ask for it
Urgent care appointments that do need a prior OK from us (this is called prior authorization)	An appointment time within 96 hours from the time you ask for it
Non-urgent care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	An appointment time within 15 business days from the time you ask for it
In-office waiting room time	You will usually not have to wait more than 15 minutes to see a doctor, nurse, or designated assistant
After-hours care (when a doctor's office is closed)	Reach a recorded message or live person giving emergency and nonemergency care instructions 24 hours a day, seven days a week; you should also be told when to expect a call back for non-emergent (urgent) matters
Emergency care* (call 911 or go to the nearest emergency room)	Immediately
Question for Anthem's customer service by telephone on how to get care or solve a problem, including mental health	10 minutes to reach a live person by phone during normal business hours (our average customer service call is answered in 45 seconds)
Question for a nurse on how to access care or solve a problem	A nurse line is available 24 hours a day, seven days a week; the number can be found on the back of your member ID card

Standard waiting times for behavioral/mental health and Employee Assistance Program (EAP) providers:

Type of care	Standard waiting time
Emergency care* (call 911 or go to the nearest emergency room)	Immediately
Emergency (not life-threatening)	6 hours
Urgent care that does not need a prior OK by us (this is called prior authorization)	48 hours
Urgent care that does need a prior OK by us (this is called prior authorization)	96 hours
Routine office visit/non-urgent care appointment	◦ 15 business days for psychiatrists ◦ 10 business days for a behavioral health care provider who is not a doctor ◦ 5 business days for EAP
After-hours care (when a behavioral health or EAP provider's office is closed)	Reach a recorded message or live person giving instructions for emergency and nonemergency care 24 hours a day, seven days a week; you should also be told how to reach a behavioral health/EAP provider and be told when to expect a call back for non-emergent (urgent) matters
In-office waiting room time	You will usually not have to wait more than 15 minutes to see a doctor, nurse, or designated assistant

*California law states that health plans follow the "prudent layperson" standard for emergency care. A "prudent layperson" is a person with an average amount of knowledge about medicine. This law does not allow plans to not pay for emergency services, even if the situation was found not to be an emergency though any "prudent layperson" would have believed it to be one. We expect all providers to tell their after-hours answering service that if a caller believes he or she is having an emergency, the caller should be told to dial 911 or go straight to the emergency room. Answering machine instructions must also tell the member to call 911 or go to the emergency room if the caller believes he or she is having an emergency.

PHOTO: THINKSTOCK

To ER or Not to ER?

What you need to know about emergency care

When you need care right away, deciding where to go can be a tough call. The emergency room (ER) may seem like a natural choice. But if it's not a true emergency, you might save money and time by going somewhere else. Plus, you can still be treated by a doctor, nurse, or physician assistant. True emergencies need ER care or a 911 call. But with non-emergencies, we can help you find other options. ER wait times are at an all-time high. Plus, an ER visit can be expensive.

So, what do you do when you need care right away, but it's not an emergency? Retail health clinics and urgent care centers can take care of many of the same health issues, illnesses, or injuries that an ER can. Plus, most are open weeknights and weekends. Calling your primary doctor is still a good first choice. Your doctor probably knows you better than anyone else. But if you can't see your doctor soon enough or if it's after hours, finding a clinic or urgent care center is easy. Just go to **anthem.com/ca/eralt** for a listing of ones in your area that can handle your care needs.

If it's not an emergency, try these options:

- **Retail health clinic (for members with PPO-type coverage):** A clinic staffed by health care professionals who give basic health care services to walk-in patients. Most are often in a major pharmacy or retail store.
- **Urgent care center without X-ray:** A doctor's office that doesn't require you to be an existing patient or have an appointment. Can handle routine care and common family illnesses.

PHOTO: MEDIA BAKERY

- **Urgent care center with X-ray:** A group of doctors who treat conditions that should be looked at right away but aren't as severe as emergencies. Can often do X-rays, lab tests, and stitches.

Each clinic or center may have different services. Before you go, be sure to call and ask:

- What are your hours?
- Do you have services that I need?
- What age range do you treat — all ages?
- Are you in my health plan network?

Let a nurse help you decide. You can also contact the 24/7 NurseLine at the telephone number listed on your identification card 24 hours a day, seven days a week. A registered nurse will listen to your questions and concerns and help you decide which type of care makes the most sense. The number is on the back of your member ID card, so you'll always have it with you. Now that you know more about your options, you'll know what to do next time you're faced with a health problem. Sometimes, the ER will be the right answer. Sometimes it won't. But knowing the difference can save you time and money without sacrificing the quality of your care.

Average plan copays:

- **ER visit:** $150
- **Retail health clinic/urgent care visit:** $10 to $40

Next Time You Need Care Right Away

1. If it's a true emergency, call 911 or go to the ER right away.

If it is not a true emergency:
2. Try calling your primary doctor.
3. Call our 24/7 NurseLine.
4. Visit **anthem.com/ca/eralt**.

Preventive Care and Immunization Guidelines

You can help keep yourself healthy and well by taking some key steps:

- See your doctor for a well check-up at least once a year.
- Bring all your medications (over-the-counter and prescriptions) with you to the check-up.
- Ask your doctor if you are up-to-date with your immunizations and preventative screening tests.
- Make positive changes in your life by not smoking, and limiting alcoholic drinks and fatty foods.
- Keep fit by exercising daily.

When you visit your doctor, ask what tests are right for you. Anthem Blue Cross has guidelines to help keep you healthy. You can request a printed copy by calling the customer service number on your ID card.

What Is the Anthem Blue Cross Drug List?

The Outpatient Prescription Drug List is a list of prescription drugs Anthem Blue Cross prefers as the first line of therapy (treatment).

Only a treating doctor can decide what drugs are best for your needs. To find out more about this drug list, call the toll-free number on your member ID card. You can also visit **anthem.com/ca**. Please check your Evidence of Coverage for benefits and drugs that are limited or excluded.

Pharmacy benefits that need a prior OK
Anthem Blue Cross reviews trends in pharmacy use each quarter to find drugs that should be part of the Prior Authorization of Benefits (PAB) Program. These select drugs are available through the PAB Program. Prior authorization means that a drug requires an OK before it can be prescribed.

Who decides what drugs are part of the PAB Program? Anthem Blue Cross uses the Formulary Review Committee, a group of doctors and pharmacists who sets rules and approves guidelines for pharmacy. This group makes sure that the guidelines reflect both the Food and Drug Administration's (FDA) standards and community prescribing standards and add to the value of the drug benefit. If a drug is prescribed outside of what the FDA says to do, we have a policy to allow coverage of the drug when medically necessary (needed for care).

Step-therapy explained
Some drugs are best used as a second choice after other drugs (ones we call first-line therapy) have been tried first. These medications are noted as step-therapy products. Here's how it works:

- A prescription for a step-therapy is given to the pharmacy. Then the online claims processor searches past claims for first-line therapy.
- The claim will be processed automatically if the member has already tried a first-line therapy.
- If a first-line therapy has not been tried, the claim will be rejected. The pharmacist should either call the plan or the doctor to talk about other prescription options.
- Finally, a small number of drugs may be limited to use in certain age or gender groups. They may have to go through the PAB process for benefit coverage. Your prescribing doctor can fax prescription drug PAB requests to **888-831-2243**.

How long it takes for PAB drug requests
The prior authorization center processes initial PAB requests for members:

- We review urgent PAB requests within 24 hours of getting the request, and non-urgent PAB requests within 2 business days, if we get all of the information we need.
- If extra information is needed or if it does not meet the approval criteria, we make a final decision within 5 business days of getting the request (72 hours for urgent requests).
- We let prescribing doctors know within 24 hours of the decision. We let members know within 2 business days.
- If a PAB request is denied, we send a letter to the prescribing doctor telling the medical reason(s) for the denial and naming the Anthem Blue Cross doctor who made the denial. We explain how to appeal the decision in the letter to the doctor. We also explain it in the letter sent to the member.
- The Anthem Blue Cross PAB process is reviewed on an ongoing basis to make sure we have timely results. In emergency cases or life-threatening situations, a 72-hour supply of a drug may be given to members.
- In some cases, drug requests are given without all the information we need to make a

Need More Details About Pharmacy Benefits?

Find a Pharmacy

To find a local pharmacy, please call the toll-free number listed on your member ID card. You also can search online:

- Go to **anthem.com/ca**.
- Click **Find a Doctor** in the Useful Tools section on the home page.
- Under Step 1, select Pharmacy.
- Under Step 2, enter the pharmacy name (optional).
- Under Step 3, select the distance and city, state, and zip code. Or enter the address, state, and county (optional).
- Under Step 4, enter the first three letters of your member ID. You can also select your state, plan type, and plan name. Or you can search all plans.

Look Up Drugs Online

It's easy to look up pricing and coverage online:

- Visit **anthem.com/ca**.
- Choose **Prescription Benefits** and log in.
- On the Pharmacy page, choose **Price a Medication**. You'll navigate to the website of our pharmacy benefits manager, Express Scripts.
- In the **Price a Medication** tool, enter a drug name to find its cost (including dose, quantity, and days' supply), and other choices that may save you money are included in the results.

Manage Your Prescriptions

To manage your prescription orders online, visit **anthem.com/ca**, choose **Prescription Benefits** in the **Useful Tools** section and then log in:

- On the Pharmacy page, choose an option in the **Pharmacy Self Service** section. You'll be directed to our pharmacy benefit manager's website.
- Manage your prescription orders in the **My Prescriptions** section on the left side of the page.
- You can see prescription order refills, check order status, and even view your history.

See your Evidence of Coverage for the pharmacy programs and benefits that apply to your health plan.

PHOTO: GETTY IMAGES

decision. When this happens, the prescribing doctor may be asked to give extra medical information so we can complete the review within 45 days. We will not make a decision until we get that extra information or the 45-day time period ends.
- If we don't get the requested information in the required time frame, a decision is made based on what is available.

Call **888-831-2242** to find out the status of a PAB request. To get PAB Request forms or a list of PAB drugs, call the toll-free number on your member ID card.

Covering drugs not on the list

We support your doctor's decision about what prescription drugs you need. In most cases, if you need a drug not on the drug list or not on the preferred drug list, your doctor can write "do not substitute" or "dispense as written" on the prescription. The prescription will be processed at the pharmacy. You may have to pay a higher cost, depending on your benefit. For some drugs, your doctor will need to begin the PAB process, and we require an internal review.

What are quantity limits?

Most pharmacy benefits allow up to a 30-day supply of a drug for the cost you pay out-of-pocket. We call this either a copay or coinsurance. Sometimes we set a quantity limit based on what the FDA recommends. If a drug has a quantity limit, it's part of the Quantity Supply Program. If a medical condition requires a greater supply than what is recommended, then PAB makes sure the member gets an appropriate quantity. Drugs in this program require an internal review by Anthem Blue Cross before being filled.

To learn more about quantity limits, call the toll-free number listed on your member ID card. You also can:

- Log in to **anthem.com/ca**.
- Select the **Customer Support** tab in the upper-right corner of the home page.
- Select the **Forms Library** tab.
- In the forms library, select the **Quantity Limits** overview.

Note: Pharmacy management procedures apply to members whose employers have opted into the program.

Dose optimization

The Dose Optimization Program is a part of the Quantity Supply Program. It helps patients stick to drug therapies. This program works with you, the member, your doctor, or health care provider and pharmacist to replace multiple doses of a lower-strength drug (where appropriate) with a single dose of a higher-strength drug. That is what dose optimization means. We do this only with the prescribing doctor's approval. To learn more, call the toll-free number on your member ID card.

Note: Pharmacy management procedures apply to members whose employers have opted into the program.

Delicious Summer Recipes

Break out of a recipe rut with these lighter versions of mealtime favorites

Grilled Veggie Pizza

1 package frozen whole wheat pizza dough
½ cup no-salt-added tomato sauce or pesto
1 cup arugula or other greens
2 cups grilled eggplant, zucchini, and mushrooms
½ red onion, thinly sliced
½ cup part-skim ricotta or goat cheese (optional)
Pine nuts (optional)

1. Defrost dough overnight in fridge.

2. Divide dough into two balls, and place on lightly greased baking sheets. Flatten each ball of dough to ½-inch thickness, and shape into crust. Place empty mugs along edges of crust, and let rest 10 minutes to hold the shape.

3. Heat grill to high. Spray crusts with cooking spray, and place on grill.

4. Cook crusts 2 minutes, then flip. Add tomato sauce, arugula, grilled vegetables, onion, and ricotta (if using). Close grill, and cook 4 to 6 minutes more.

5. Remove pizzas from grill, and cool 5 to 10 minutes. Garnish with pine nuts (if using). Cut each pizza into 4 slices, and serve.

Servings: 8

Per Serving: 163 calories, 3.5 g fat, 1 g saturated fat, 7 g protein, 29 g carbs, 6 g fiber, 272 mg sodium

Zesty Fish Tacos

SAUCE:
2 roasted red peppers, chopped
¼ cup cherry tomatoes
6 sprigs parsley, chopped
Juice of 1 lime
Pinch of light brown sugar

TACOS:
4 flounder or tilapia fillets (3 ounces each)
4 corn tortillas, warmed
½ cup no-salt-added black beans, rinsed, drained, and warmed
½ cup shredded cabbage

1. Blend sauce ingredients for 30 seconds in a food processor. Set aside.

2. Spray skillet with cooking spray, and set over medium-high heat. Season fish with black pepper, and cook 3 to 4 minutes on each side. Cut fish into chunks.

3. Fill tortillas with beans, fish, and cabbage. Top with sauce.

Servings: 4

Per Serving: 244 calories, 2.5 g fat, 0 g saturated fat, 22 g protein, 35 g carbs, 7 g fiber, 156 mg sodium

PHOTOS: THINKSTOCK (LEFT); ALAMY (RIGHT)

UM, UR, Medical Necessity Review

Here's what it all means and how it works

The doctor or health care provider you see works with you and Anthem Blue Cross to give you care and services you need that we cover. This means that both your plan and your doctor must agree that the care or service is what we call a "medical necessity." What makes something "a medical necessity" and when care requires this review varies based on your benefit plan.

A "medical necessity review" may be called many things like utilization review (UR), utilization management (UM), or medical management. It is a review process that helps decide if a certain outpatient care, inpatient hospital stay, technology, or procedure is medically needed.

Reviews of a medical service, treatment, or procedure can happen at different times including:

- **When it is asked for or planned ahead:** We call this prospective or pre-service review.
- **During the course of care:** We call this inpatient or outpatient ongoing care review.
- **After care or services have been given:** We call this retrospective or post-service review.

With so many different things to consider, it may help to get a clear picture of what to expect and how the process works.

Timing matters
We're committed to deciding cases quickly. Here are several time frames you can expect:

Type of review	The maximum time allowed for a health plan to decide medical necessity once it gets the information needed to do so
Non-urgent pre-service (before care)	5 business days
Urgent pre-service (before care)	72 hours
Urgent inpatient or outpatient ongoing care (during care)	24 hours (in specific instances, no later than within 72 hours of getting a request)
Retrospective/ post-service (after care)	30 calendar days

UM Questions? Call Us

If you want to learn more about a UM medical decision, pre-authorization requests, the UR review process, or have questions or issues, call our toll-free number: **800-274-7767**. We can help you Monday through Friday (except holidays) from 7:30 a.m. to 5 p.m., PST.

If you call after hours or don't reach a "live" person during business hours, leave a confidential voice mail message with your name and phone number. We will return your call no later than the next business day, unless you request another time.

You also can call the customer service number on your ID card to ask for an interpreter in your preferred language. He or she can read UM information in another language or help explain it in your preferred language. The service is free.

If you have a hearing or speech loss, dial 711 to use the National Relay Service or one of the numbers below. A special operator will contact Anthem to help with your needs:

800-735-2929 (English TTY) or
800-735-2922 (English Voice)

What happens if there is a delay?
If we don't have the information we need to make a decision, we try to get it from the doctor or other health care provider who requests the service or care.

If we think there might be a delay because the information we need is not easy to get, we will write to let both you and the requesting doctor or health care provider know of the delay. This letter tells you what we need to make a decision. It also explains when to expect the decision once we get the information.

If we don't get the information we need, we will send a final letter explaining that we are unable to approve access to this benefit due to lack of information.

Professional reviewers decide
Anthem Blue Cross' doctor reviewers and the medical groups' doctors or their peers are licensed health care professionals. They are qualified and able to review requests and give an opinion specific to a medical condition, procedure, and/or treatment under review.

If the reviewer is unable to decide the medical necessity of a request, he or she may call the requesting doctor or other provider to discuss the case. In many cases, medical necessity can be determined after this call.

Decisions are based on what is right for each member based on the type of care and service. Medically necessary review decisions made by Anthem Blue Cross are based on:

- Anthem medical policy criteria and guidelines (reviewed at least once a year and updated as standards and technology change).
- Nationally-recognized clinical guidelines approved by a committee including practicing doctors and health care professionals not employed by Anthem Blue Cross.
- Your health benefits.

Associates, consultants, or other providers are not rewarded or offered money or other incentives for denying care or a service, or for supporting decisions that result in using fewer services. Also, Anthem doesn't make decisions about hiring, promoting, or firing these individuals based on the idea or thought that they will deny benefits.

Medical necessity doesn't mean payment or coverage
If we find services are medically necessary, it doesn't mean the service is paid for or covered.

PHOTO: THINKSTOCK

Payment is based on the terms of your coverage at the time of service. There are some exclusions, limitations, and other conditions that are part of your benefits. You will find them in your Evidence of Coverage. Payment of benefits could be limited for a number of reasons, such as:

- Information included with the claim differs from that given at time of review.
- The service performed is excluded from coverage.
- You are not eligible for coverage when the service is given.

Decisions not to approve are put in writing
If we find the service is not a medical necessity, you and your doctor or health care provider requesting it will get written notice sent to you within two business days of the decision. This written notice has:

- A clear and simple explanation of the reason for the decision.
- The name of the criteria and/or guidelines used to make the decision and instructions for how to obtain a written copy.
- Information on how to appeal the decision and about your rights to an independent medical review.
- Specific parts of the contract that exclude coverage if the denial is based upon benefit coverage.

To see our guidelines
Anyone can see Anthem Blue Cross' medical necessity guidelines for specific services:

- Just go to **anthem.com/ca**.
- Click **Customer Support** in the upper-right of the screen.
- Under Top FAQs, click **Anthem-CA Medical Policies**.
- Click on **click here** where it says: For detail around Anthem's Medical Policies, please click here.
- Use the scroll bar on the right to scroll down and click **Continue**; you will see the Medical Policies and Clinical UM Guidelines Overview page.
- Click on the applicable option in the upper blue toolbar: **Medical Policies** or **UM Guidelines**.
- Choose the link for the desired search option: **Recent Updates**, **By Category**, **By Alpha**.

You may also call **800-794-0838** to request a free paper copy of the guidelines used to determine your case. These guidelines are used by Anthem Blue Cross to authorize, change, or deny benefits for people with similar illnesses or conditions. Specific care and treatment benefits vary based on individual need and covered benefits.

PHOTO: MASTERFILE

Beat the Scale

Smart strategies to reach your healthiest weight

Between cookouts, gatherings, and vacations, keeping a healthy weight can feel like a constant battle at this time of year. But with some simple strategies, you can be at your happiest, healthiest weight all season, every season. Follow these steps from Adam Glasgow, MD, medical director at Steward Norwood Hospital Weight Loss Center in Norwood, MA:

Avoid gaining new weight

On average, Americans gain a pound a year, according to a recent study in the *New England Journal of Medicine*. That can add up over time. But avoid gaining that pound in the first place, and you've given yourself an advantage.

Give yourself time

Think about long-term healthy habits you can maintain instead of aiming to drop pounds quickly, Dr. Glasgow says. If you're able to get in your bathing suit at the beginning of summer but can't fit into it at the end of summer, you're not doing that much good for your health. Losing a pound a week is more realistic.

Aim to lose 5%

"Losing just 5% builds your confidence that you can do it," Dr. Glasgow says. Plus, if you're overweight now, losing 5% lowers your risk for high cholesterol, high blood pressure, and even diabetes.

Plan to indulge

Going to a dinner or party? Don't starve yourself. Start your day with a workout and healthy breakfast if you know you're going to be around indulgent foods later that day. Eat a healthy meal or snack beforehand so you're not tempted to binge on less-healthy foods.

Weight Loss Success Secret

Try this: Step away from the scale. Checking your weight can help you keep track of your progress. But it's also smart to not only focus on the scale. Celebrate all the activities you're able to do at a healthy weight, like being able to play with your kids or running a 5K.

Recruit a buddy

Get a friend to join you in your weight management plan so you can keep each other accountable. "There's a great deal to be gained from being in a supportive environment," Dr. Glasgow says.

Lose the guilt

Craving a slice of pie? "Say, 'I'm going to enjoy this without guilt,'" Dr. Glasgow says. "One day, one meal should not set you off track." As long as you don't let one moment of indulgence turn into several moments, days, or weeks of indulgence, you can still enjoy delicious foods while losing weight.

How to File a Grievance or Appeal a Decision

This process applies if you're covered by Anthem Blue Cross or Anthem Blue Cross Life & Health Insurance Company (Anthem). To find out, check your member ID card.

If you are unhappy with the care or service you received from Anthem Blue Cross or a contracting medical group or health care provider, you can file a complaint. We call this a "grievance." If you disagree with a denial of treatment or payment of a claim, you can "appeal" the decision.

You have up to 180 calendar days from the date you get a denial notice or the date of an incident or dispute to file a grievance or appeal unless your plan documents state otherwise. If there is a good reason, we may extend the time frame for filing a grievance or appeal.

Choose one of these ways to submit a grievance or appeal to us.

- **Member Grievance Form:** Complete a Member Grievance Form. You can get it from your medical group or by calling customer service at the toll-free phone number on your member ID card. Mail the completed form to ANTHEM BLUE CROSS, ATTN: PRIORITY MEMBER GRIEVANCES, PO BOX 60007, LOS ANGELES, CA 90060-0007.
- **Customer Service:** Call customer service to file a verbal grievance or appeal.
- **Website:** File a grievance/appeal at our website. Go to **anthem.com/ca**. Under the heading Customer Care, you will see "I need to." Under that, click on **File an appeal or grievance**. Follow the instructions. The site has copies of all the forms you can download to use. It also explains how to use them.

For emergency complaints
For any emergency grievance or appeal, please call customer service right away at the toll-free number on your member ID card.

You can choose a representative like an attorney or health care expert to file a grievance or appeal for you. You will be asked to complete and sign an authorization form so that person can represent you.

What to include with your appeal
You should include with your appeal (if available):

- The member's name and ID number;
- The name of the provider or facility that provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you do not agree;
- The reason(s) why you do not agree with the decision.

You have the right to submit written comments, documents, or other key information with your appeal. We encourage you to do so.

What happens next?

- The appropriate administrative and/or clinical specialists review your appeal.
- We review all information you or your representative submits.
- We may contact any providers who may have more information to support your appeal.
- The reviewers can't have been involved in the initial decision. They also can't work for the person who made the initial decision.
- We will send you a written decision within 30 calendar days of getting your grievance or appeal. If your condition is urgent, you can ask for an expedited review of your grievance or appeal. Anthem will then provide you with a written decision within 72 hours.
- If we deny your appeal, we give you other options, including external review, if available. You also can refer to your plan documents or call customer service at the telephone number on your member ID card to get detailed information about the appeal process.

Speak another language?
We can help you or any member who prefers to speak in a language other than English and those with vision, speech, or hearing loss by providing:

- Translation services for letters and written materials (through customer service).
- An interpreter in a language other than English (through customer service).
- Telephone relay systems.
- Other devices to aid people with disabilities.

For members enrolled in Anthem Blue Cross plans*
The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-365-0609** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The

Attn: ERISA plan members

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), once you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

*To identify the company that provides your plan, check your member ID card.

PHOTO: THINKSTOCK

department's **Internet Web site http://www.hmohelp.ca.gov** has complaint forms, IMR application forms, and instructions online.

For members enrolled in Anthem Blue Cross Life & Health Insurance Company plans*
You may contact:
CALIFORNIA DEPARTMENT OF INSURANCE
CONSUMER AFFAIRS BUREAU
300 SOUTH SPRING STREET
SOUTH TOWER
LOS ANGELES, CA 90013
800-927-HELP (4357)

What's an Independent Medical Review (IMR)?
As a member, you can apply to the DMHC or California Department of Insurance (CDI) (whichever applies) for an IMR within 6 months of a qualifying event. You may request an IMR after filing an appeal with us and:

- The denial is upheld; or
- The appeal remains unresolved after 30 calendar days or after 72 hours for expedited reviews. After receiving an initial denial of investigational treatment, you don't have to go through the Anthem grievance and appeal process before you request an IMR.

When the DMHC or CDI decides your appeal qualifies for an IMR, Anthem provides the requested medical information within required time frames to an Independent Review Organization (IRO) picked by the DMHC or CDI. Anthem must follow the decision of the IRO.

If services are approved, we notify you and your provider in writing within 5 business days. If services are denied, the DMHC or CDI notifies you in writing, explaining the reason for the denial. Check your Combined Evidence of Coverage and Disclosure for more about grievance procedures and the IMR process.

Call customer service
If you or a representative filed a grievance or appeal, you can call the customer service number on your member ID card with any questions or requests for information about your case.

Language Assistance Program Reaches Out to California Members

Our Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials that are vital to understanding your health coverage — at no additional cost to you.

Written materials available for translation include but are not limited to: grievance and appeal letters, consent forms, claim reject letters, and explanations of benefits. These documents are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance. If you have a hearing or speech loss, dial 711 to use the National Relay Service or one of the numbers below. A special operator will contact Anthem to help with your needs.

800-735-2929 (English TTY)
800-735-2922 (English Voice)

For more information about the Language Assistance Program, visit **anthem.com/ca**.

*To identify the company that provides your plan, check your member ID card.

Protecting Your Privacy — Where to Find Our Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties, and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect. (It will remain in effect unless and until we publish and issue a new notice.) You may obtain a copy of our Notice of Privacy Practices on our website at **anthem.com/ca**, or you may contact Member Services using the contact information on your identification card.

State Notice of Privacy Practices

As we indicate in our HIPAA Notice of Privacy Practices, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use, and share your nonpublic personal information (PI) as described in this notice. PI is information that identifies a person and is often gathered in an insurance matter.

If we use or disclose PI for underwriting purposes, we are prohibited from using or disclosing PI that is genetic information of an individual for such purposes.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out of that activity, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

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